CMA focuses on GST's "fundamental unfairness" to MDs in brief to Commons committee

Patrick Sullivan

Résumé : En mars, le Conseil d'administration de l'AMC a approuvé la présentation, à la Chambre des communes, d'un mémoire qui aborderait franchement les répercussions que la taxe sur les produits et services a eues sur les médecins canadiens. Présenté à un comité de la Chambre des communes le 15 mars par une délégation de l'AMC dirigée par le président, le Dr Richard Kennedy, le mémoire précise que depuis l'entrée en vigueur de la taxe en 1991, il en a coûté aux médecins canadiens 175 millions de dollars en taxes que d'autres professionnels n'ont pas eu à payer. Le Conseil d'administration a aussi approuvé une politique de l'AMC sur l'inconduite sexuelle des médecins à l'égard des patients, et décidé que les cotisations de 1995 demeureraient gelées au niveau de 1994. Il a appris aussi que la profession médicale s'inquiète de plus en plus des efforts que déploient les pharmaciens pour étendre leur champ d'activité.

The CMA has delivered a blunt message to parliamentarians about the impact the goods and services tax (GST) is having on physicians.

In a brief in which diplomacy took a back seat to indignation, the association warned a House of Commons committee that physicians "have not accepted, nor can we accept, a perpetuation of the fundamental injustices built into the current GST arrangements."

The brief, approved by the Board of Directors on Mar. 6, was presented to the House of Commons Standing Committee on Finance Mar. 15. The CMA delegation was led by Dr. Richard Kennedy, the president. The committee is currently studying the GST; replacing it with another type of tax was a key plank in the Liberal Party's 1993 election platform.

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Dr. Léo-Paul Landry, the CMA secretary general, said the brief's basic message is that "enough is enough." It was designed to "zero in on the fundamental unfairness of this tax to physicians. We've tried to drive home the attempts we've made to convince the government of this and to explain why physicians are so angry."

In presenting the brief, Kennedy said that in the 3 years since the GST was introduced it has cost Canadian physicians $175 million in taxes that other professionals have not had to pay, and costs him $1500 annually. The reason: physicians are not allowed to claim rebates for GST they pay in operating their practices or to claim input tax credits, and they are unable to pass the higher cost on to patients. Lawyers, on the other hand, charge clients GST and then claim credits for all GST costs related to their businesses. "Only physicians," said Kennedy, "are caught in the catch-22 of being ineligible for input tax credits and unable to adjust prices to cover the added GST costs of practice."

He outlined steps the CMA has taken to make the federal government aware of the tax's impact on the medical profession and pointed out that even though "considerable time, effort and money" was spent submitting a detailed study to the minister of finance in July 1992, "we are still waiting for a policy response."

The brief, which asked the committee to ensure that "physicians pay no more than other professions or occupation groups under the replacement tax for the GST," argued that Ottawa has been using the GST to "indirectly tax" medical services. The CMA hopes the brief, which offered 10 recommendations, will bring to an end its numerous initiatives concerning the GST. These began with an initial presentation in 1989 when the federal government announced plans to replace the federal sales tax with the GST.

Since then, said Kennedy, physicians' "anger and frustration" has grown. He said the "serious tax injustice" that has existed since 1991 "must not be perpetuated by any replacement tax — it simply will not do."

During its Mar. 5-7 meeting the board also received an update on a report being prepared by the Working Group on Health System Financing in Canada, which will be presented to General Council in August. Among other things, the report will

CMA sexual-abuse policy sets national standards for physicians

The CMA says physicians have an ethical duty to protect patients if they have reasonable grounds to believe that sexual abuse has occurred in any patient–physician relationship and they must "take every reasonable step" to ensure that such behaviour is reported.

That is one key point in the new *CMA Policy on the Patient–Physician Relationship and Sexual Abuse of Patients*. The seven-page document, the result of lengthy consultation with outside bodies, received final approval from the Board of Directors Mar. 6.

"This involved a great deal of discussion with 38 external organizations," said Dr. Barry Adams, chairman of the Council on Health Care. He told the board sexual abuse is an "evolving issue" and the CMA may have to re-examine its policy periodically.

The policy, which Adams said was "very difficult" to formulate, states that the patient–physician relationship is "the foundation of medical practice" but the relationship may be unequal: "Physicians are in a position of power because they have the necessary medical knowledge and skills required to help their patients and they also have the trust of their patients."

The CMA has defined abuse by physicians as "any behaviour that transgresses the patient–physician relationship in an exploitative manner."

The policy states that transgressions can involve words or actions but responds to concerns raised by many physicians by reassuring them that they should feel free to discuss sexual issues with patients. "Such practices are not considered sexually abusive. Asking patients questions about sexual practices, concerns and history is an important component of clinical interviewing and decision making."

However, "as part of appropriate and sensitive care" the CMA encourages doctors to explain to patients the medical reasons for addressing sexual issues, such as sexually transmitted diseases, and to outline the procedures for physical examinations.

The policy says there should never be "sexual or romantic involvement" between doctors and their current patients, although the issue of physicians practising in isolated areas "where every member of the community is a potential patient" merits further study.

The CMA also says that the most important factor to be considered when deciding whether it is acceptable for a physician to enter into a relationship with a former patient is the potential for the doctor to exploit the trust, knowledge and dependency that developed during the professional relationship.

"I think the policy we have developed will help both patients and the profession."

— Dr. Barry Adams

When doctors think a patient may have been abused by a colleague, they should inform the patient of his or her right to make a report to a disciplinary body; if the patient chooses not to, the doctor should seek permission to make the report.

The CMA also encourages the referral of people who have been abused to support programs. "The medical profession has a particular responsibility to ensure that treatment is available by encouraging physicians to undertake the necessary training to understand, treat and refer patients who have been sexually abused."

While acknowledging the right of patients and physicians to have a third party present during an examination or meeting, the CMA warns that this presence does not necessarily protect either party and may be counterproductive in some situations, such as individual counselling. The presence and identity of a third party should be mutually acceptable to both parties and both have the right to refuse an examination "if there is no agreement made regarding presence or identity of a third party.

"Whether a third party is present or not, a physician has a responsibility to establish office policies and practices that minimize the likelihood of abuse. A physician must respect the privacy of patients and follow appropriate procedures such as the draping of patients and making arrangements that provide for their privacy when changing."

The policy also stresses that the CMA and its divisions have important roles to play in educating physicians about abuse and says confidential help lines should be developed to encourage physicians with potential behavioural problems to seek early intervention.

The policy concludes by dealing with one of physicians' major concerns about sexual-abuse issues: procedural fairness. It says "certain minimum standards" must be followed during all stages of the complaints and disciplinary processes.

Adams concluded that sexual abuse is a "very difficult area in which to create policy but I think the policy we have developed will help both patients and the profession."

discuss the role private health care and health insurance should play in Canada.

Dr. Hugh Scully, the working group chairman, told the board Canada is the world's "silver medallist" when it comes to health care spending — the US wins the gold — and warned that Canada may not be able to maintain this level of spending in the face of a growing mountain of debt and an increasingly competitive global economy.

Scully said spending in the private health care sector has risen steadily in Canada over the past 20 years and accounted for 28% of total spending in 1991. However, one area that remains firmly entrenched in the public sector is physicians' fees: 97% of physician earnings in Canada is paid by the public sector. The working group will present its final report to the Board of Directors in May. At the March meeting the board also:

• Received a progress report on the development of a CMA policy on physician-assisted death. The final document will be submitted to General Council during the annual meeting in August.

• Received an update on revisions to the CMA Code of Ethics. Dr. Doug Sawyer, chairman of the Committee on Ethics, said the revised code will be presented to General Council in 1995. In an interview, Landry described the revision "as a major initiative — any time a profession revises its Code of Ethics, it is a major undertaking." He said the revision will involve "extensive consultations" inside and outside the CMA. "This is a major strategic issue for the CMA. The work has already been going on for a long time and we have over a year's work to do before the job is finished."

• Accepted a Committee on Finance recommendation that CMA membership dues be frozen at the 1994 level, $260, for 1995.

• Gave CMA endorsement to the new Canadian Medical Hall of Fame, which is being created in London, Ont. "I feel this is a positive move," said Kennedy. "The hall will honour the leaders in our profession."

• Decided that the CMA will "make a general statement" about the Canadian blood system to the commission of inquiry that is currently studying the system. It was created in response to concerns about contamination of blood and blood products with HIV in the early 1980s.

• Supported recommendations contained in the Canadian Cancer Society's action plan to control contraband and tax-exempt tobacco. The plan includes calls to encourage higher tobacco taxes in the US and the implementation of plain-packaging regulations.

• Learned that the CMA is "very encouraged" by its membership recruitment efforts, particularly in Ontario, and that 1993 membership results were "significantly more positive" than initial predictions. Barbara Drew, the CMA's executive director, praised the Ontario Medical Association (OMA) for its support. "I'd publicly like to thank Dr. [Tom] Dickson [the president] and Dr. [Michael] Thoburn [the past president]," she said. "They provided a great deal of help and we're very grateful to them." She also noted that Anne Todd, the OMA's director of financial services, and her staff had provided "superb support" for the recruiting initiatives.

• Were told that the CMA's March Leadership Conference attracted the largest number of registrants since the conferences began in 1988. "What we're trying to do with these conferences," said Landry, "is tackle tomorrow's issues today — we want to be on the cutting edge of policy development." The board was also told that the 1994 conference is expected to be in the black, a first since the conferences began. ■

Pharmacists may pose new challenge to physicians' role, CMA board told

Most physicians already realize that their role is being challenged by the emergence of midwives and nurse practitioners, but the CMA's Council on Health Care thinks a new challenger is now making an appearance: pharmacists.

Dr. Anne Carter, the CMA's associate director of health care and promotion, advised the Board of Directors in March that community pharmacists are seeking to redefine their role because of the advent of mail-order pharmacy and the disappearance of the need for pharmacists to compound medications.

"Community pharmacists are attempting to carve out a new role," said a discussion document prepared by the Council on Health Care. The document says this can be seen in the development of a concept called "pharmaceutical care," in which the pharmacist would determine the appropriateness of a therapy and monitor response to it. (The model is described in an Ontario Ministry of Health document.)

The proposed model concerns the council. Carter said good therapeutic decisions require a broad knowledge of clinical medicine and of the patient and of the patient's environment, and not just a diagnosis. She said the council is also worried about the potential fragmentation of care.

One board member said pharmacists' attempts to change their role is another sign "of the increasing marginalization of our own job descriptions."

The board decided that the CMA will continue to monitor the issue. In the meantime, the Department of Health Care and Promotion will seek further information and reactions from CMA divisions and affiliated societies.